DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

October 22, 2010

Kim C. Stanger
Hawley Troxell Ennis & Hawley LLP
877 Main Street, Suite 1000
Boise, ID 83701-1617

CMS Certification Number: 13-1304

Dear Ms. Taylor:

Thank you for submitting Harms Memorial Hospital's response to the EMTALA citations and the plan of correction dated September 29, 2010, and the supplemental information received October 15, 2010. The Centers for Medicare and Medicaid Services (CMS) determined that Harms Memorial Hospital's allegation of compliance is credible.

The proposed termination action from CMS' September 17, 2010, letter is suspended pending review of the plan of correction implementation evidence. At this time, there is no planned on-site revisit in follow-up to this Emergency Medical Treatment and Labor Act (EMTALA) investigation. Rather, CMS is requesting that you submit the following documentation to Kate Mitchell in the Seattle Regional Office by December 15, 2010 at the latest:

- Attendance log of staff who attended the October 1, 2010, EMTALA training;
- Minutes from HMH's Performance Improvement Committee summarizing the review of ED patient encounters to confirm MSEs were conducted by QMPs;
- Minutes from the Medical Staff meeting where the revised EMTALA Policy and amendments to Medical Staff By-Laws were reviewed and approved; and
- A list of RNs who have completed and met QMP requirements.

If you have questions regarding this letter, please contact Kate Mitchell, of my staff at (206) 615-2432 or by e-mail at catherine.mitchell@cms.hhs.gov.

Sincerely,

Steven Chickering
Western Consortium Survey and Certification Officer
Division of Survey and Certification

cc: Idaho Bureau of Facility Standards
Kim Stanger, Hawley Troxell Ennis & Hawley LLP

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IMPORTANT NOTICE – PLEASE READ CAREFULLY

September 17, 2010

Dallas Clinger, Administrator
Harms Memorial Hospital
510 Roosevelt Street (PO Box 420)
American Falls, ID 83211

CMS Certification Number: 13-1304

Re: Complaint Intake # 4675 (EMTALA)

Dear Mr. Clinger:

To participate in the Medicare program, a critical access hospital must meet the requirements established under title XVIII of the Social Security Act (the Act) and the regulations established by the Secretary of Health and Human Services under the authority contained in §1861 (e) of the Act. Further, §1866 (b) of the Act authorizes the Secretary to terminate the provider agreement of a critical access hospital that fails to meet these provisions.

Your critical access hospital was surveyed July 27-29, 2010, by the Idaho Bureau of Facility Standards (State Agency) based on an allegation of noncompliance with the requirements of 42 Code of Federal Regulations (CFR) § 489.24 Responsibilities of Medicare Participating Hospitals in Emergency Cases and /or the related requirements at 42 CFR § 489.20. After a careful review of the findings, we have determined that your critical access hospital violated:

- **The requirements of 42 CFR § 489.24(a) based on failure to provide an appropriate medical screening exam; and**

- **The requirements of 42 CFR § 489.24(d) based on failure to provide necessary stabilizing treatment for emergency medical conditions.**

The deficiencies identified are listed on the enclosed form CMS-2567, Summary Statement of Deficiencies.

The purpose of this letter is to notify you of these violations and advise you that under 42 CFR § 489.53, a critical access hospital that violates the provisions of 42 CFR § 489.20 and/or 42 CFR § 489.24 is subject to termination of its provider agreement. Consequently, it is our intention to terminate Harms Memorial Hospital's participation in the Medicare program. The projected date on which the agreement will terminate is **December 16, 2010**.

You will receive a "Notice of Termination" letter no later than December 1, 2010. This final notice will be sent to you concurrently with notice to the public in accordance with regulations at 42 CFR § 489.53.

You may avoid termination action and notice to the public either by providing credible allegation or credible evidence of correction of the deficiencies, or by successfully proving that the deficiencies did not exist, prior to the projected public information date. In either case, the information must be furnished to this office so that there is time to verify the corrections. An acceptable plan of correction (POC) must contain the following elements:

- The plan of correcting each specific deficiency cited;
- The plan should address improving the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- All plans of correction must demonstrate how the hospital has incorporated its improvement actions into its Quality Assessment and Performance Improvement (QAPI) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements; and
- The plan must include the title of the person responsible for implementing the acceptable plan of correction.

It is highly recommended that the latest completion date in the plan of correction be no later than **October 18, 2010**. Please submit the POC within 10 days receipt of this letter, to the State survey agency and to the following address:

CMS – Survey, Certification, and Enforcement Branch
Attn: Kate Mitchell
2201 Sixth Avenue, RX-48
Seattle, WA 98121
Fax: (206) 615-2088

A credible allegation of correction by the critical access hospital may require a resurvey to verify the corrections. However, when evidence of correction is provided by the critical access hospital, this office must decide whether the evidence of correction is sufficient to halt the termination action. If the evidence is not sufficient in itself to establish that the hospital is in compliance, a resurvey is required for verification of correction.

If we verify your corrective action, or determine that you successfully refuted the findings contained in this letter by proving that allegations were in error, your termination from the Medicare program will be rescinded.

If you have any questions concerning this preliminary determination letter, please contact Kate Mitchell of my staff at (206) 615-2432.

Sincerely,

Steven Chickering
Western Consortium Survey and Certification Officer
Division of Survey and Certification

Enclosure

cc: Idaho Bureau of Facility Standards
Office of Civil Rights (OCR)
Complainant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131304	A. BUILDING _____ B. WING _____	C 07/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMS MEMORIAL HOSPITAL	510 ROOSEVELT STREET AMERICAN FALLS, ID 83211

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C 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey conducted at your critical access hospital. Surveyors conducting the investigation were: Gary Guiles RN, HFS, Team Leader Patrick Hendrickson, RN, HFS Acronyms used in this report include: DO = Doctor of Osteopathy DON = Director of Nursing ED = Emergency Department EMTALA = Emergency Medical Treatment and Active Labor Act ER = EmergencyRoom FNP = Family Nurse Practitioner et = and IV = intravenous line MD = Medical Doctor MSE = Medical Screening Examination n.p.o. = nothing per os, a medical order for a patient to not eat or drink anything OTC = over the counter PA = Physician Assistant PCP = primary care provider RN = registered nurse x = times	C 000		
C2400	489.20(l) COMPLIANCE WITH 489.24 [The provider agrees,] in the case of a hospital as defined in §489.24(b), to comply with §489.24. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, hospital policies, and meeting minutes, it was determined the hospital failed to ensure	C2400		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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C2400	Continued From page 1 emergency services were provided in compliance with 42 CFR Part 489.24. This resulted in the lack of an apprpriate MSE, or the lack of an MSE by qualified medical professionals, for 3 of 31 ER patients (#27, #30 and #31) whose medical records were reviewed. In addition. this resulted in the lack of stabilizing treatment for 1 of 31 patients (#11) whose medical records were reviewed. Findings include: 1. Refer to C2406 as it relates to the failure of the hospital to provide appropriate MSEs to ER patients. 2. Refer to C2407 as it relates to the failure of the hospital to provide stabilizing treatment to an ER patient with an emergency medical condition. The failure to provide MSEs and stabilizing treatment resulted in the hospital's inability to appropriately diagnose and treat emergency patients.	C2400		
C2406	489.24(a) and 489.24(c) MEDICAL SCREENING EXAM Applicability of provisions of this section. (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must (i) provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined	C2406		

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C2406	Continued From page 2 qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and (b) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section. (2) Nonapplicability of provisions of this section. Sanctions under this section for inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of the Act. A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided for by section 1135(e)(1)(B) of the Act. (c) Use of Dedicated Emergency Department for Nonemergency Services If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request	C2406		

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C2406	Continued From page 3 makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, hospital policies, and meeting minutes, it was determined the hospital failed to ensure 3 of 31 ER patients whose medical records were reviewed (#27, #30 and #31), received appropriate Medical Screening Examinations by appropriately qualified personnel. This resulted in the inability of the hospital to ensure patients were not discharged with undetected emergency medical conditions. The findings include: 1. Two patients received MSEs by unqualified staff. Examples include: a. Patient #27's medical record documented a 21 year old female who presented to the ER on 6/23/10 at 11:35 PM. The form "EMERGENCY ROOM RECORD," was written by Staff A, an RN. The note, dated 6/23/10 at 11:35 PM, stated Patient #27 complained of "feeling like she's not getting any air. [right] arm tingling. Light headed. 2 hrs ago." The note stated Patient #27 had been smoking an herbal marijuana substitute called "Black Mamba." Her vital signs were-blood pressure 143/96, pulse 77, respirations 18. The nursing note stated the examination was unremarkable. The bottom of the form contained boxes for discharge information. These boxes	C2406		

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C2406	Continued From page 4 indicated Patient #27 was discharged home, was ambulatory, and was given discharge instructions. The time of discharge was not documented. Under the heading "DISCHARGE SUMMARY," not timed, the form stated "EMTALA screening done. [Patient] to follow up [with] her PCP within the week." Discharge vital signs were documented at 12:30 AM on 6/24/10. These included blood pressure 126/74, pulse 66, and respirations 18. No documentation was present that the RN had spoken to a physician or other provider about Patient #27. Staff A was interviewed on 7/28/10 at 10:50 AM. He confirmed he had performed the MSE on Patient #27 on 6/23/10. He stated he thought he had spoken by telephone to the Nurse Practitioner who was on call for the hospital on 6/23/10. He said he did not know if he had documented this or not. Staff A's personnel file was reviewed with the Director of Human Resources on 7/28/10 at 11:20 AM. His "EMPLOYEE ORIENTATION CHECKLIST," dated 6/09/10, contained an box for "ER Patient Screening video." Most of the items on the checklist were checked but this item was not. The Director confirmed the documentation and stated Staff A had not been approved by the hospital to conduct MSEs. She presented surveyors with "Credentialing Sheets" for 9 RNs which stated these nurses had been approved to conduct medical screening examinations. Staff A did not have a Credentialing Sheet. The hospital's Board of Directors Meeting minutes for 5/17/10 approved the Credentialing Sheets to conduct MSEs for the 9 nurses as noted above.	C2406		

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C2406	Continued From page 5 Staff A was not listed as a nurse who was approved to conduct MSEs. The DON was interviewed on 7/29/10 at 9:00 AM. She stated Nurse A was not approved to conduct MSEs. She said a list of nurses that were approved to conduct MSEs was not available to staff or to providers. Patient #27's MSE was performed by unqualified staff. b. Patient #31's medical record documented a 78 year old male who presented to the ER on 6/09/10 at 9:15 PM. The form "EMERGENCY ROOM RECORD," written by Staff A and dated 6/09/10 at 9:15 PM, stated Patient #31 complained of lower abdominal pain and had "[large] blood in his urine x1 week ago." The nursing note stated Patient #31 had severe pain in his abdomen which decreased after he urinated. The note stated Patient #31 had been seen by at a clinic but did not state when that was. The note stated Patient #31 had blood in his urine until 6/09/10. The note stated Patient #31's current pain level was 2 of 10. The note documented a physical examination by the RN. The note stated Staff A called the Nurse Practitioner who asked him to conduct the medical screening examination. Under the heading "DISCHARGE SUMMARY," dated 6/09/10 at 10:15 PM, the RN documented Patient #31 was to follow up with his PCP or come back to the emergency room if the pain returned. Staff A was interviewed on 7/28/10 at 10:50 AM. He stated he had performed the MSE on Patient #31.	C2406		

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C2406	Continued From page 6 Patient #31's MSE was performed by unqualified staff. 2. The hospital failed to provide direction to nurses who performed MSEs. The policy "MEDICAL SCREENING EXAM-ER EMTALA," approved 11/14/07, stated all patients presenting to the Emergency Department would receive an MSE by "Qualified Medical Personnel (QMP), which may be any active member of the Medical Staff (DO, MD) or mid-level practitioners (PA, FNP), or Registered Nurses, (RN) who have been approved to perform the MSE in consultation with an on-call provider who is an active member of the Medical Staff. The policy stated "The approved RN will complete the MSE, following the 'ED Patient History Form' and will contact the on-call provider immediately." A form labeled "ED Patient History Form" was not included with the policy. The only form present in the 9 medical records that were reviewed, where an RN performed the MSE, was the form titled "EMERGENCY ROOM RECORD." This was a 2 sided form that contained identifying information, the chief complaint, admission and discharge vital signs, and a nursing assessment that consisted of boxes to check. For example, the section of the nursing assessment labeled "Speech" had a choice of 6 boxes the nurse could check, such as "Incoherent, Silent, Crying," etc. This assessment did not contain areas for the nurse to write descriptions in addition to the boxes to check. The second page of the form contained a section for nursing notes, a discharge summary, a section to document medications and fluids that were given, and sections for transfer or discharge. This was the same form that nurses used when the MSE was completed by a physician.	C2406		

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C2406	Continued From page 7 Staff B and Staff C, RNs who performed MSEs, were interviewed on 7/28/10 at 4:20 PM and 7:50 PM, respectively. Both RNs stated they performed the same assessment whether a physician performed the MSE or the nurse conducted the examination. Both RNs stated they did not perform any kind of special examination if they were performing the MSE. Both nurses stated they documented either assessment the same way. The DON, interviewed on 8/02/10 at 4:00 PM. She stated there was no form labeled "ED Patient History Form." She stated nurses used the form titled "EMERGENCY ROOM RECORD" to document the MSE and no special forms were used. 3. One patient received an incomplete MSE by a nurse as per the following example: a. Patient #30's medical record documented a 40 year old female who presented to the ER on 6/19/10 at 4:50 PM. The form "EMERGENCY ROOM RECORD," was written by Staff D, an RN. The form, dated 6/19/10 at 4:50 PM, stated Patient #27 complained of a headache since 3:00 AM that day. Patient #27 stated her pain had a severity of 10 out of 10. The form stated Patient #30 routinely took Lamictal-a drug for seizures and bipolar disorder, Lexapro-an antidepressant, Ambien-a sleeping pill, Trazadone-an antidepressant, and extended release Morphine and Norco for pain. The form at 4:50 PM described the MSE by the RN. Patient #30's headache was not described. The nursing note at 4:50 PM stated Patient #30 "Has not taken any of her [prescribed] pain meds because 'the	C2406		

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C2406	Continued From page 8 morphine makes me nauseated and I threw up 3 times.' After discussing with [a physician], medicated pt for nausea with injection." A nursing note at 5:20 PM stated "Reports nausea feeling improved. Able to take washcloth off face & walk into lighted room." She was discharged at 5:25 PM with a pain level documented at 5 of 10. A medical history was not documented. A history of her headaches was not described. The reasons Patient #30 had been prescribed 4 psychotropic medications and 2 narcotic pain medications was not documented. Her psychiatric history was not described. Patient #30's medication compliance history was not documented to determine if she was going through withdrawal. The nursing assessment described Patient #30 as oriented and stated her pupils were reactive to light. Otherwise, a neurological examination was not documented. Staff D was interviewed on 7/28/10 at 4:00 PM. She confirmed the documentation. She stated she had conducted the medical screening examination for Patient #30. She stated 6/19/10 was her first encounter with Patient #30. She said Patient #30 had a history of back pain and headaches but had not taken the Morphine for 4 days due to nausea. She stated this was not documented. She stated she did not know Patient #30's psychiatric history. Patient #30's MSE was incomplete and did not include a medical history or a complete neurological assessment.	C2406		
C2407	489.24(d)(1-3) STABILIZING TREATMENT (1) General. Subject to the provisions of paragraph (d)(2) of this section, if any individual	C2407		

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C2407	Continued From page 9 (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either- (i) within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition. (ii) For for transfer of the individual to another medical facility in accordance with paragraph (e) of this section. (2) Exception: Application to inpatients. (i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual (ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment. (iii) A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation. (3) Refusal to consent to treatment. A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's	C2407		

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C2407	Continued From page 10 behalf) does not consent to the examination or treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both. This STANDARD is not met as evidenced by: Based on staff and family interviews and review of medical records, hospital policies, and meeting minutes, it was determined the hospital failed to ensure 1 of 31 ER patients whose medical records were reviewed (#11), received stabilizing treatment for pain. This resulted in the inability of the hospital to ensure patients were stabilized prior to transfer or discharge. The findings include: Patient #11's medical record documented a 6 year old male who was brought to the emergency room by his father after falling from a slide. The form "EMERGENCY ROOM RECORD," written by Staff B and dated 6/26/10 at 9:40 PM, stated Patient #11 had fallen and complained of left arm pain. The form stated Patient #11 had a "deformity" of his left elbow. The form stated his pain rating was 10 of 10 and he was "crying histerically." An xray of the arm was documented at 9:55 PM. The nursing note at that time stated Patient #11 was crying and difficult to console. The nursing note dated 6/26/10 at 10:05 PM,	C2407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131304	A. BUILDING _____ B. WING _____	C 07/29/2010

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C2407	Continued From page 11 stated Patient #11's arm was splinted and he continued to cry hysterically. The final nursing note, dated 6/26/10 at 10:15 PM, stated Patient #11 was "...carried out of ER by Dad, will be transferred to [another hospital] via private car. Pt in stable condition but continues to cry." Patient #11's pain was rated at 8 of 10 at the time of transfer. Patient #11 was transferred to another hospital approximately 27 miles away. The xray report, for the xray taken at 9:55 PM on 6/26/10, was dictated 6/27/10 at 11:54 AM. The report stated Patient #11 had a fracture of his ulna and a dislocated radius [forearm bones]. The "Emergency Room Report" by Staff G, the physician who treated Patient #11, was dictated on 6/26/10 at 10:38 PM. The report stated Patient #11 "...is crying incessantly though and is in a significant amount of pain. There is also some mild growth deformity of the elbow." The report stated the 6 year old patient "...declined any kind of shot for pain." Patient #11's father was interviewed by telephone on 7/28/10 at 8:25 PM. He stated Patient #11 was in severe pain while at the hospital. He stated it was especially painful when the xray technician manipuated the arm for the xray. The father stated he asked the physician for pain medication to treat the child. He said the physician refused. Staff B, the RN that treated Patient #11, was interviewed on 7/28/10 at 4:20 PM. She stated the child was screaming and writhing in pain. She stated she offered to give Patient #11 pain medication but the physician refused.	C2407		

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C2407	Continued From page 12 Staff G, the physician who treated Patient #11, was interviewed on 7/28/10 at 2:45 PM. He stated Patient #11 was in a lot of pain but said the child did not want a shot for pain so he did not order it. He said the arm was splinted and ice was applied. An IV was not inserted while Patient #11 was at the hospital. Staff G said he did not remember why he did not order an IV. The medical record from the receiving hospital stated Patient #11 was admitted there at 11:05 PM on 6/26/10. The receiving hospital started an IV shortly after admission and administered a narcotic pain medication with relief. Patient #11 was then examined by an orthopedic surgeon who later performed a closed reduction and pinning of his elbow. Harms Memorial Hospital failed to provide stabilizing treatment by not administering pain medication prior to transferring Patient #11.	C2407		

HARMS MEMORIAL HOSPITAL

PLAN OF CORRECTION

(September 29, 2010)

Tag	Deficiency	Corrective Action	Due Date	Assigned Responsibility	Completion Date
C2406	Performance of MSE by persons designated as "qualified medical personnel"	1. Ensure that Nurse Jeremy Pinock is identified as a qualified medical personnel ("QMP") permitted to perform medical screening examinations ("MSEs") per HMH policies.	10/18/10	Alice Taylor, Risk Manager	
		2. Modify HMH's policy to clarify that RNs are QMPs for purposes of EMTALA, and that they do not require specific credentialing by the HMH Board before they may perform MSEs.	10/18/10	Alice Taylor, Risk Manager	
		3. Provide training for hospital staff concerning HMH's policy for MSEs, including the identity and qualifications of those persons who may perform MSEs. The training will be conducted by John O'Hagan, a regional expert on EMTALA issues. We will obtain and maintain a list of participants. We will forward a copy of the training materials to Region X, if desired. The training is currently scheduled for October 1, 2010.	10/18/10	Alice Taylor, Risk Manager	
		4. Review all emergency department patient encounters on at least a weekly basis for a period of 60 days to confirm that MSEs are conducted by QMPs consistent with HMH's policy. The review will be conducted by HMH's Director of Nursing/Risk Manager, Alice Taylor, and the results will be shared with HMH's Performance Improvement Committee on a monthly basis.	10/18/10	Alice Taylor, Risk Manager	
C2406	Performing and documenting appropriate screening	1. Review the facts and citations related to Patient 30 with Nurse Permann. We will also require Nurse Permann to review HMH's EMTALA policies concerning conducting and documenting appropriate MSEs. We will document the review	10/18/10	Alice Taylor, Risk Manager	

	examination	in her employee file.			
		2. Provide training for hospital staff concerning the requirements of an appropriate MSE and documenting same. The training will be conducted by John O'Hagan. We will obtain and maintain a list of participants. We will forward a copy of the training materials to Region X, if desired. The training is currently scheduled for October 1, 2010.	10/18/10	Alice Taylor, Risk Manager	
		3. Consistent with HMH's current policy, HMH currently requires that licensed independent practitioners review all emergency department medical screening exams performed by RNs to review the care, including the results of the screening examinations. HMH will continue that practice for at least six months from the date of this plan of correction. The results of the reviews will be shared with HMH's Performance Improvement Committee on a monthly basis.	10/18/10	Alice Taylor, Risk Manager	
C2407	Providing stabilizing treatment	1. Require Dr. Timmons and Nurse Scherer to review HMH's EMTALA policies concerning stabilizing emergency patients.	10/18/10	Alice Taylor, Risk Manager	
		2. Provide training for hospital staff concerning EMTALA requirements for stabilizing emergency department patients. The training will be conducted by John O'Hagan. We will obtain and maintain a list of participants. We will forward a copy of the training materials to Region X, if desired. The training is currently scheduled for October 1, 2010.	10/18/10	Alice Taylor, Risk Manager	
		3. Review all emergency department patient encounters on at least a weekly basis for a period of 60 days to confirm that appropriate stabilizing treatment was rendered. The review will be conducted by Alice Taylor, and the results will be shared with HMH's Performance Improvement Committee on a monthly basis.	10/18/10	Alice Taylor, Risk Manager	